Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 23, 2016

Ms. Morgan Bovat, Manager
Brownway Residence
328 School Street
Enosburg Falls, VT 05450-5500

Dear Ms. Bovat:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 12, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0118	A. BUILDING: _____ B. WING _____	C 07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNWAY RESIDENCE	328 SCHOOL STREET ENOSBURG FALLS, VT 05450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite investigation of self reports and complaint were conducted on 07/11/16 by the Division of Licensing and Protection and completed on 07/12/16. The following are Residential Care Home licensing regulation violations.	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed by staff interview the facility failed to update the written plan of care for 2 of 5 residents reviewed describing the care and services necessary to assist the resident in maintaining independence and well being. For Residents #1 and #5 the findings include the following: 1. Per medical record review, Resident #1's mental health condition deteriorated to the point that other residents of the home were threatened and attacked. The care plan gave no specific tangible interventions to direct staff when aggressive behaviors were noted. The care plan update on 04/20/16 instructs staff for 'Hourly safety checks by staff to ensure that resident is not smoking in his room, is not engaged in self harming activities and is either in his room or	R145	See Attached	

R145 - R226 POCs accepted 8/19/16 SEMMONS RN/PMP

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R145	Continued From page 1 common spaces where (resident) can be adequately supervised. Staff to immediately report any aggressive or threatening gestures or communications that (Resident) has with other residents or staff. Nursing will communicate with crisis regarding any changes in status and/or threats to self harm or hurt others'. On 6/20/16 the care plan also notes "Staff to call (Administrator) immediately and provide 30 minute safety checks following any verbal or physical altercations with other residents". There was limited documentation that hourly and or 30 minutes checks were consistently provided from 04/20/16 through the end of June 2016. The Administrator (ADM) acknowledged that the safety checks were implemented only after being directed by the ADM. The care plan has no specific immediate interventions for staff to follow prior to escalating behaviors. 2. Resident #5 has past medical history of Generalized Anxiety Disorder and Psychosis. The care plan states "monitor and notify nursing for any negative behaviors outside of baseline. Resident to be placed on 30 minute safety checks for negative behaviors or changed mental health status". On 05/09/16 the resident complained of hearing voices and requested that the Guardian assist with "[seeing] a specialist, I want to get this straightened out". There are no intervention updates to the care plan after this expressed concern although the resident was seen by the primary care provider on 05/23/16. A progress note of 06/25/16 (around 11:00 PM) states that the resident was telling staff that they need to give (him/her) something to help (resident) sleep. Resident does not have any current active medications on medication list. Staff notified to help resident relax by putting on soft music, deep breathing, warm heat pack or	R145	See Attached	

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R145	Continued From page 2 decaffeinated tea. {This notification was not revised into the care plan.} The note further states "Resident did not want to try any of these measures. At around 0000 (Midnight), resident becoming angered that staff would not give (him/her) anything to sleep. Resident sent (self) out to the hospital via ambulance by calling 911, stating (s/he) did this because staff could not help(him/her)". On 07/06/16 a text note states "Resident exhibiting paranoid and agitated behaviors this morning - resident running around the building and shouting at the voices (s/he) is hearing." Ultimately, Crisis was called, resident was evaluated and put on 30 minute checks and an appointment with the psychiatrist was made. The ADM on 07/12/16 at 2:00 PM confirmed there were no have specific interventions written in the care plan after these episodes. Also see R-208.	R145	See Attached	
R146 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: The RCH failed to provide instruction to staff regarding 1 of 5 residents' health care needs during transport. (Resident #3) Findings include: 1. Resident #3, who has a diagnosis of	R146		

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R146	Continued From page 3 dementia, hard of hearing and amputation, was left in the facility's van for over an hour, with no way to alert staff. As reported from a concerned citizen, "noticed Resident #3 waving and trying to get people's attention at the physician office for greater than 1 hour". Per the report from the RCH and subsequent follow up on 04/05/16 the Administrator stated that the transport staff left Resident #3 in the van for approximately 1.5 hours while bringing two other residents to their appointments. The transport staff stated "the resident fell asleep but it was not too hot or cold... and...did check on the resident". The Administrator further stated that the transport staff has received education regarding the need to return residents to the facility following appointments rather than having them sit waiting in the van. During interview on 07/12/16 at 12:10 PM, the Administrator acknowledged "it is not our policy to do that" [leave a resident in the van]. S/he confirmed that instruction was not given, at that time, regarding the care needs of this resident.	R146	See Attached	
R188 SS=B	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent	R188		

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R188	Continued From page 4 photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that 3 of 5 resident records included all of the required information. (Resident #1, #2 & #5) Findings include: 1. Per record review, Residents #1, #2 and #5 have no recent photos nor objections to having a photo documented in their charts. The Administrator, during interview at 2:00 PM, confirmed the above findings.	R188		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the Residential Care Home (RCH) did not develop a	R208	See Attached	

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R208	Continued From page 5 specific care plan to deal with the repeated aggressive behaviors for 1 of 5 residents in the sample. (Resident #1) Findings include: Per record review on 07/11/16 a pattern of aggressive behaviors involving Resident #1, occurred over a two month period in which no plan was developed to deal with the behaviors. The pattern of aggressive behaviors, per progress notes, occurred between 04/06/16 and 06/28/16. Initial care plan dated October 2015 for behaviors states the following: "Encourage resident to participate in daily activities and social interactions with other residents. Monitor for negative behaviors or changed mental health status. Monitor resident for inappropriate social behaviors, intervene as necessary..." A care plan update on 04/20/16 instructs staff "Hourly safety checks by staff to ensure that resident is not smoking in his room, is not engaged in self harming activities and is either in his room or common spaces where (resident) can be adequately supervised. Staff to immediately report any aggressive or threatening gestures or communications that (Resident) has with other residents or staff. Nursing will communicate with crisis regarding any changes in status and/or threats to self harm or hurt others." On 6/20/16 the care plan also notes "Staff to call (Administrator) immediately and provide 30 minute safety checks following any verbal or physical altercations with other residents". Resident #1 continued to have aggressive, threatening and assaulting behaviors towards two residents (Resident #4 & Resident #5) between 06/17/16 and 06/26/16. Furthermore, a Care Conference note with the	R208	See Attached	

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R208	Continued From page 6 NMC (Mental Health Community) on 06/22/2016 denotes the following. "The NMC representatives express concern that this has occurred before on different occasions and that a plan needs to be in place to prevent use of the hospital for management of aggressive behaviors." Per interview on 07/12/16 at 10:09 AM the Administrator stated "the [staff] are not able to communicate with [resident]- so that is why they call me". The Administrator acknowledged that this plan is a reaction to the aggressive behaviors, which do not prevent others residents from being harassed, threatened and attacked.	R208		
R224 SS=E	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, all residents of the home were not free from mental, verbal or physical abuse. Findings include: 1. Per multiple self reports and an outside complaint, Residents #2, #3, #4, #5 and #6 specifically, were not free from verbal and physical abuse by Resident #1. The progress notes show that Resident #1 continued behaviors of aggression, threats, assault harassment towards other residents for food, drinks and cigarettes from April to beginning of July 2016. A facility report dated 04/18/2016 demonstrated that Resident # 1 told Resident #6 to "shut up or I	R224	See Attached	

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R224	Continued From page 7 will f...ing kill you". Resident #6 stated that Resident #1 was harassing Resident #2, who was in the bathroom, for cigarettes. On 06/17/16, according to staff report, Resident #1 came into the building calling Resident #4 an foul inappropriate name. The employee determined there was a verbal altercation with Resident #1, threatening Resident #4 "to punch (#4) in the face and knock (him/her) out". On 06/19/16 the staff progress notes demonstrated Resident #1 charged and punched Resident #5 for failure to provide cigarettes. The progress note of 06/27/16 demonstrated that Resident #5 flagged the sheriff down at the end of the driveway to report that another resident, Resident #1, had threatened to "murder" (him/her). The Sheriff reports that Resident #5 was visibly upset, and after talking with that resident, decided to speak to Resident #1. The Sheriff stated that if there were anymore threats that Resident #1 would go to jail. Per interview on 07/12/16 at 10:09 AM the Administrator indicated that Resident #1 was admitted in October 2015 but started to display increased behaviors in April 2016. At that time, Resident #1 was found going through room mates belongs, using the phone excessively and/or inappropriately and harassing residents for cigarettes. The Administrator stated that they were working on getting further community service and "(staff) are not able to communicate with (Resident #1), so that is why they call me and I speak to (him/her)." The Administrator acknowledged that despite speaking with Resident #1 multiple times, the threats and abuse continued.	R224	See Attached	

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R224	Continued From page 8 Also see R-145 and R-208	R224		
	Also see -R-208			
R226 SS=D	VI. RESIDENT'S RIGHTS 6.14 Residents subject to transfer or discharge from the home, under Section 5.3 of these regulations, shall: 6.14.a Be allowed to participate in the decision-making process of the home concerning the selection of an alternative placement; 6.14.b Receive adequate notice of a pending transfer; and 6.14.c Be allowed to contest their transfer or discharge by filing a request for a fair hearing before the Human Services Board in accordance with the procedures in 3 V.S.A. §3091. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to respect the right for	R226	See Attached	

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R226	Continued From page 9 alternative placement for 1 applicable (Resident #1). The findings include the following: Per the RCH self report and a Hospital report, Resident #1 went to the emergency room on 06/20/16 to be evaluated for behaviors. According to both sources, the RCH (Brownway)refused to accept the return of Resident #1. The resident requested to go back to Brownway. As the resident had no place to return, he/she was admitted under observation status. Per the hospital report on 06/21/16 states that Resident #1 had an altercation yesterday, but the resident was sent today for medical clearance. It was reported from Brownway, [Resident #1] has apparently a diagnosis of bipolar and [the] behaviors were manic in nature. Brownway then refused to allow [resident #1] to return to Brownway stating that [the] behaviors were unmanageable. The patient was medically clear (all lab work and imaging not requiring further hospital evaluation or treatment, and could have been administered at either urgent care or primary care) and "not appropriate for hospital stay". The patient does not warrant a psychiatric evaluation as [s/he] was calm, cooperative and pleasant in the ED for more than 6 hours. Despite the stability, Brownway refused to allow [resident #1] back despite [him/her] having no change in care needs. There is no substantial physician documentation in the resident's record that the discharge or transfer was an emergency measure necessary for the health and safety of the resident or other residents. There is no documentation that Resident#1 was allowed to participate in the decision-making process for the refusal back to the home or the overnight stay in the hospital. The Administrator acknowledged there is no documentation as evidence that the	R226	See Attached	

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R226	Continued From page 10 resident agreed to stay in the hospital.	R226	See Attached	

R145

5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;

1. Action to correct the deficiency

Plan of care for Resident #1 and #5 were updated to reflect tangible and specific interventions to correct behaviors that were aggressive in nature.

Expected completion date: Completed (7/14/2016)

2. Measures to assure that it does not recur

Service plan template in the electronic health record has been updated to reflect a behavioral focus which includes 10 tangible interventions for aggressive behaviors which must be used prior to the intervention which instructs staff to call the Administrator to assist in triaging the behaviors.

Expected completion date: Completed (7/14/2016)

3. How corrective actions will be monitored

All Residents with behavioral care plans will be monitored by the Administrator and the Health Services Director on a weekly basis.

Expected completed date: Ongoing

R146

5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate;

1. Action to correct the deficiency

While the Transportation Coordinator is not considered "direct care personnel", Brownway Residence, Inc. has implemented a facility wide policy which prevents Residents from being left "unattended" regardless of their level of independence, physical or mental health status.

Expected completion date: Completed (7/14/2016)

2. Measures to assure that it does not recur

See attachment #1

Expected completion date: Completed (7/14/2016)

3. How corrective actions will be monitored

Resident Services Director will be responsible for doing random check-ins/monitoring with Residents to ensure that Transportation policies and procedures are being followed through on.

Expected completed date: Ongoing

R188

5.12.b (2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any.

1. Action to correct the deficiency

Photos were able to be obtained for Resident #1 and #2 and a refusal was documented for Resident #5.

Expected completion date: Completed (7/14/2016)

2. Measures to assure that it does not recur

Admission paperwork has been changed to reflect a "refused photograph" field to provide documentation of refusals in the future.

Expected completion date: Completed (7/14/2016)

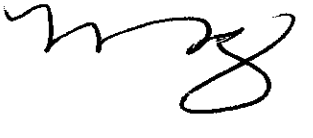
3. How corrective actions will be monitored

All admission documents are reviewed by the Resident Services Director at the time of admission – refusal field must be completed if no photograph is obtained.

Expected completed date: Ongoing

R208

5.18 Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-toresident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors.



1. Action to correct the deficiency

While each resident to resident altercation was reported to the licensing agency as the regulations indicate, the interventions put in place were not deemed tangible by the licensing agency as evidenced in **R145.** Plan of care was updated to reflect tangible interventions.

Expected completion date: Completed (7/14/2016)

2. Measures to assure that it does not recur

Service plan template in the electronic health record has been updated to reflect a behavioral focus which includes 10 tangible interventions for aggressive behaviors which must be used prior to the intervention which instructs staff to call the Administrator to assist in triaging the behaviors.

Expected completion date: Completed (7/14/2016)

3. How corrective actions will be monitored

All Residents with behavioral care plans will be monitored by the Administrator and the Health Services Director on a weekly basis.

Expected completed date: Ongoing

R224

6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.

1. Action to correct the deficiency

Team meeting with Community Partners on 6/22/2016, following a brief hospital stay, for Resident #1 created a long term plan to support this individual. Resident #1 without resident to resident altercations since long term plan initiated.

Expected completion date: Completed (6/22/2016)

2. Measures to assure that it does not recur

Brownway Residence will continue to advocate for residents and community supports for those residents which require additional services that are not able to be easily accessed.

Expected completion date: Ongoing

3. How corrective actions will be monitored

All Residents with behavioral care plans will be monitored by the Administrator and the Health Services Director on a weekly basis.

Expected completed date: Ongoing

R226

6.12 Residents subject to transfer or discharge from the home, under Section 5.3 of these regulations, shall: 6.14.a Be allowed to participate in the decision-making process of the home concerning the selection of an alternative placement; 6.14.b Receive adequate notice of a pending transfer; and 6.14.c Be allowed to contest their transfer or discharge by filing a request for a fair hearing before the Human Services Board in accordance with the procedures in 3 V.S.A. §3091

1. Action to correct the deficiency

Resident was not discharged or **attempted to be discharged** – Administration insisted the resident remain at the hospital following continued resident to resident altercations (see **R224**) until the team meeting between community partners occurred so that resident would return to his home with the adequate amount of support Resident #1 and the other 49 residents required to function safely in this environment. Per nursing note dated 6/21/2016: **"This writer expressed concern over previous history with this resident and explained that services are not able to be accessed at this time. This writer indicates that Brownway will not accept this resident back until an appropriate plan and services are in place."**

Resident #1 was accepted back to the facility following the team meeting on 6/22/2016 which outlined an appropriate long term plan for community supports. Resident #1 has been successful and without any resident to resident altercations since his readmission now that the proper community supports are in place and onboard with adequately supporting this individual.

Expected completion date: Completed (6/22/2016)

2. Measures to assure that it does not recur

Brownway Residence will continue to advocate for residents and community supports for those residents which require additional services that are not able to be easily accessed.

Expected completion date: Ongoing

Attachment #1

Brownway Residence

DEPARTMENT: Transportation

LICENSING CATEGORY: N/A

SUBJECT: Leaving Residents in the Vehicle

Policy:

It is the policy of Brownway Residence, Inc. that Residents never be left unattended while being transported to and from appointments/outings.

Procedure:

For safety reasons, Residents are **never to be left unattended** inside the vehicle. If a Resident is located inside the vehicle and the driver is outside the vehicle, the vehicle must be in park, the parking brake must be engaged and the vehicle must remain in the Drivers field of vision. Under this circumstance, the resident should only be unattended for a very short period of time (while the Driver is assisting another resident into an appointment)

There may be times when a transport of 2 or more Residents may occur. If the Residents are not agreeable to going into the medical office and waiting in the waiting room with the Driver, the following procedure should be followed:

- Resident with the appointment should be loaded/unloaded at the front door of the medical office/appointment and safely assisted into the building. Reception should be notified that the driver will be located in the parking lot inside the Brownway vehicle with the other resident(s) Reception should be given the business card with the Brownway Transportation Phone Number to ensure adequate communication occurs.